

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2012
NAME OF PROVIDER OR SUPPLIER DEACONESS HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 600 MARY ST EVANSVILLE, IN 47747		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one (1) State complaint.</p> <p>Date of survey: 12-05-12</p> <p>Facility number: 005074</p> <p>Complaint number: IN00115006 Unsubstantiated, Lack of sufficient evidence</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>Deaconess Hospital is in compliance with 410 IAC 15-1.5-6, Nursing services and 410 IAC 15-1.6-2, Emergency services, Hospital Licensure Rules.</p> <p>QA: cloughlin 12/14/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1